Assembly Bill No. 3142

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Passed the Assembly August 30, 1996

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Chief Clerk of the Assembly

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Passed the Senate August 19, 1996

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Secretary of the Senate

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This bill was received by the Governor this ___ day of _____, 1996, at ___ o'clock __M.

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Private Secretary of the Governor

CHAPTER ____

An act to amend Section 12725 of, and to add Sections 10198.61 and 10701 to, the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 3142, Granlund. Insurance: health coverage.

Existing law limits exclusions for preexisting conditions or late enrollees by a health benefit plan. Under existing law, a health benefit plan is a group or individual policy or contract that provides medical, hospital, and surgical benefits, but does not include accident only, credit, disability income, and certain other forms of coverage.

Existing law regulates health benefit plans offered by small employer carriers. Under existing law, a health benefit plan is a policy or contract written or administered by a carrier that arranges or provides health care benefits for the covered eligible employees of a small employer and their dependents, but does not include accident only, credit, disability income, and certain other forms of coverage.

This bill would also exclude from both definitions of ''health benefit plan'' set forth above, policies or certificates of specified disease and policies or certificates of hospital confinement indemnity if the carrier offering those policies or certificates files a certificate with the Insurance Commissioner containing specified information.

Existing law establishes the Major Risk Medical Insurance Program, in which persons unable to secure adequate private health coverage may apply for health coverage. To be eligible, a person must have been rejected for coverage by at least one private health plan.

This bill would provide that rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described, shall not be deemed to be rejection for the purposes of

determining eligibility for the Major Risk Medical Insurance Program.

The people of the State of California do enact as follows:

SECTION 1. Section 10198.61 is added to the Insurance Code, to read:

10198.61. (a) For purposes of this article, ‘‘health benefit plan’’ does not include policies or certificates of specified disease or hospital confinement indemnity provided that the carrier offering those policies or certificates complies with the following:

(1) The carrier files, on or before March 1 of each year, a certification with the commissioner that contains the statement and information described in paragraph (2).

(2) The certification required in paragraph (1) shall contain the following:

(A) A statement from the carrier certifying that policies or certificates described in this section (i) are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance, health care service plans, or major medical expense insurance, (ii) the disclosure forms as described in Section 10603 contains the following statement prominently on the first page: ‘‘This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance,’’ and (iii) are not being offered, marketed, or sold in a manner that would make the purchase of the policies contingent upon the sale of any product sold under Sections 10700 and 10718, or under Section 1357 of the Health and Safety Code.

(B) A summary description of each policy or certificate described in this section, including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender, or other factors, charged for the policies and certificates in this state.

(3) In the case of a policy or certificate described in this section and that is offered for the first time in this

state on or after January 1, 1997, the carrier files with the commissioner the information and statement required in paragraph (2) at least 30 days prior to the date such a policy or certificate is issued or delivered in this state.

(b) As used in this section, ''policies or certificates of specified disease'' and ''policies or certificates of hospital confinement indemnity'' mean policies or certificates of insurance sold to an insured to supplement other health insurance coverage as specified in this section. An insurer issuing a ''policy or certificate of specified disease'' or a ''policy or certificate of hospital confinement indemnity'' shall require that the person to be insured is covered by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

SEC. 2. Section 10701 is added to the Insurance Code, to read:

10701. (a) For purposes of this chapter, ''health benefit plan'' does not include policies or certificates of specified disease or hospital confinement indemnity provided that the carrier offering those policies or certificates complies with the following:

(1) The carrier files, on or before March 1 of each year, a certification with the commissioner that contains the statement and information described in paragraph (2).

(2) The certification required in paragraph (1) shall contain the following:

(A) A statement from the carrier certifying that policies or certificates described in this section (i) are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance, health care service plans, or major medical expense insurance, (ii) the disclosure forms as described in Section 10603 contains the following statement prominently on the first page: ''This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance,'' and (iii) are not being

offered, marketed, or sold in a manner that would make the purchase of the policies contingent upon the sale of any product sold under Sections 10700 and 10718, or under Section 1357 of the Health and Safety Code.

(B) A summary description of each policy or certificate described in this section, including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender, or other factors, charged for the policies and certificates in this state.

(3) In the case of a policy or certificate that is described in this section and that is offered for the first time in this state on or after January 1, 1997, the carrier files with the commissioner the information and statement required in paragraph (2) at least 30 days prior to the date such a policy or certificate is issued or delivered in this state.

(b) As used in this section, ‘‘policies or certificates of specified disease’’ and ‘‘policies or certificates of hospital confinement indemnity’’ mean policies or certificates of insurance sold to an insured to supplement other health insurance coverage as specified in this section. An insurer issuing a ‘‘policy or certificate of specified disease’’ or a ‘‘policy or certificate of hospital confinement indemnity’’ shall require that the person to be insured is covered by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

SEC. 3. Section 12725 of the Insurance Code is amended to read:

12725. Each resident of the state meeting the eligibility criteria of this section and who is unable to secure adequate private health coverage is eligible to apply for major risk medical coverage through the program. To be eligible for enrollment in the program an applicant shall have been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage which the applicant could secure would (1) impose substantial waivers which the program

determines would leave a subscriber without adequate coverage for medically necessary services, or (2) would afford such limited coverage, as the program determines would leave the subscriber without adequate coverage for medically necessary services, or (3) would afford coverage only at an excessive price, which the board determines is significantly above standard average individual coverage rates. Rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described in Section 10198.61, shall not be deemed to be rejection for the purposes of eligibility for enrollment. The board may permit dependents of eligible subscribers to enroll in major risk medical coverage through the program if the board determines the enrollment can be carried out in an actuarially and administratively sound manner.

Approved _____, 1996

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Governor